Student Health Information Form

Please complete information on both sides

Confidentiality

This medical questionnaire is required from all University of the Cumberlands students. Your information will be kept confidential, according to certain legal and ethical guidelines. Your information will be available only to the Office of Student Services staff and supervisory medical staff (athletic training, physician, hospital, etc).

Student Information

Name: _____ Date of Birth: _____
(Last) (First) (Middle)

Social Security Number: _____ Height_____ Weight_____ Male_____ Female_____

Permanent Address: _____
(Street) (Apt.) (City) (State/Province) (Zip/Postal Code) (Country)

Permanent Telephone: _____ Cell Phone: _____

Emergency Contact Name: _____ Address: _____

Emergency Contact Telephone Home: _____ Work/Cell: _____

Medical Services

Primary Care Physician: _____ Telephone: _____

Health Insurance Information: _____
(Company) (Policy#)

Health Information

Do you have any health problems? (circle one) YES NO

If yes, please describe_____

_____

_____

What allergies (if any) do you have <u>other</u> than seasonal or environmental allergies? _____

_____

Please list all prescription and over-the-counter medication you are taking: _____

_____

(Please complete required Immunization Information on back side)

Student Immunization Record

TO STUDENT: **This completed form must be submitted prior to registration for your first term at UC.** This requirement may be met in **one of two** ways. Please check **one** box:

- ☐ Have a physician complete this form.
- ☐ Obtain a copy of your complete immunization certificate and attach it to this form.

Name: _____Date of Birth_____

A. Tetanus - Diphtheria
Tetanus –Diphtheria booster must be within the last ten years……..____/____
Mo Yr

B. M.M.R. (Measles, Mumps, Rubella) (two doses required or individual vaccine as noted below)
Dose 1 given at 12 months after birth or later and Dose 2 after 1980……1. ____/____2.____/____
Mo Yr Mo Yr

C. Polio
1. Completed primary series of polio immunization: Yes _____ No _____ Date of last booster:…… ____/____
Mo Yr
2. Type of vaccine: Live (OPV) _____ Inactivated (IPV) _____ Enhanced Potency (EP-IPV) _____

D. Tuberculosis (*PPD required regardless of prior BCG inoculation)*
1. PPD (Mantoux) within the [past 12 months (tine or momovac not acceptable)
Result: Neg_____ Pos_____ mm induration (horizontal diameter)_____.....____/____
Mo Yr
2. If greater than 5mm induration, chest X-ray required. X-ray result: Normal_____ Abnormal_____
3. Received BCG: Yes_____ No____ If yes:……..____/____
Mo Yr
4. PPD prior to last 12 months: Yes_____ No_____ mm duration (horizontal diameter) ___

E. Polio
1. Completed primary series of polio immunization: Yes_____ No_____ Date of last booster……..____/____
Mo Yr
2. Type of vaccine: Live (OPV) _____ Inactivated (IPV)_____ Enhanced Potency (EP-IPV)_____

F. Hepatitis B (strongly recommended)…1. Completion of at least two of three required doses: 1. ____/____ 2. ____/____ 3. ____/____
Mo Yr Mo Yr Mo Yr
2. Hepatitis B surface antigen antibody…….. ____/____ Reactive____Non-Reactive____
Mo Yr

G. Meningitis (recommended)……Vaccinated _____/_____
Mo Yr

I have read the information provided by University of the Cumberlands explaining the risks of Hepatitis B and Meningococcal Disease (Meningitis) and the effectiveness of the vaccines. I acknowledge that meningococcal disease is a rare, but life-threatening illness. I understand that under University of the Cumberlands policy, residential students are required to be vaccinated against Hepatitis B and Meningococcal disease. With this waiver, I seek exemption from this requirement. I voluntarily agree to release, discharge, indemnify and hold harmless University of the Cumberlands, its officers, employees and agents from any and all costs, liabilities, expenses, claims, demands, or causes of action on account of any loss or personal injury that might result from my decision not to be immunized.

For individuals 18 years of older: Signature of student: _____

Date: _____

For individuals under the age of 18: Signature of parent/guardian: _____

Date: _____

Signature of Health Care Provider _____